Received: 30 May 2022 | Revised: 12 December 2022 | Accepted: 4 January 2023

DOI: 10.1111/jan.15572

JAN Leading Global Nursing Research WILEY

SCOPING REVIEW

Nurses' and midwives' perceptions and strategies to cope with perinatal death situations: A systematic literature review

Cristina Garcia-Catena[1] | Pablo Ruiz-Palomino[2] | Steven Saavedra[3] | Juan D. Gonzalez-Sanz[4]

[1]Son Llatzer Hospital, Palma de Mallorca, Spain

[2]Business Administration Department, University of Castilla-La Mancha, Cuenca, Spain

[3]Interdisciplinary Gender Studies Doctoral Program, University of Huelva, Huelva, Spain

[4]Nursing Department, COIDESO Research Center, University of Huelva, Huelva, Spain

Correspondence
Juan D. Gonzalez-Sanz, Facultad de Enfermería (Nursing Faculty), Campus El Carmen, Universidad de Huelva, Huelva 21071, Spain.
Email: juan.gonzalez@denf.uhu.es

Abstract

Aim: The aim of this paper is to describe the strategies used by nurses and midwives to cope with experiences of dealing with perinatal death and maintain their satisfaction at work.

Design: Systematic literature review, in accordance with the PRISMA Declaration.

Data Sources: (2000–2021) Web of Science, PubMed, Scopus, CINALH and Dialnet, for articles in English and Spanish from the period between January 2000 and March 2021.

Review Methods: The outcome of the review was the perceptions of nurses and midwives who have cared for people in a situation of perinatal loss.

Results: Thirteen studies were identified that evaluated the attitudes, experiences and needs of these healthcare professionals. The combined size of all samples was 2196 participants.

Conclusions: The negative effects on these professionals' satisfaction with their situation at work could be mitigated by covering their needs for knowledge, experience, and emotional and technical skills to deal with such events.

Impact: As potential protective factors against dissatisfaction in nurses and midwives during perinatal death experiences, we identified older age and experience in perinatal care and coping strategies based on communicating one's feelings to peers, empathetic listening to the families cared for, training and institutional support.

No Patient or Public Contribution.

KEYWORDS
coping strategies, midwives, nursing, perceptions, perinatal death, satisfaction at work

1 | INTRODUCTION

Motherhood is associated with success, life, happiness and joy (Chan et al., 2003; Pastor Montero et al., 2011), and midwives/nurses care for women during this stage, whether it is successful or whether a perinatal death occurs (Fenwick et al., 2007). If perinatal death happens—that is, the death of a foetus at more than 28 weeks of gestation or the death of a newborn <1 month old, including miscarriage and neonatal death (Chan et al., 2010)—mothers and their families suffer perinatal bereavement. This is an emotional response to a major loss that produces specific symptoms—such as sadness, irritability, depression and sleep and appetite disorders (Shorey et al., 2017)—which can be said to help overcome the loss (Martos-López et al., 2016).

Although perinatal death is an immensely negative experience, especially for the mothers and the rest of the family, this issue is also crucial for nurses and midwives because perinatal death can not only be traumatic for women and families but can also reduce the quality of nurses' and midwives' care. It can even negatively affect the psychosocial well-being of these professionals (Van Horne

et al., 2020), ultimately limiting their job performance and impacting the emotional well-being of the women and families they treat (Dahò, 2021). Indeed, many nurses/midwives experience grief when a patient dies (Jonas-Simpson et al., 2013; Shorey et al., 2017), which may lead them to withdraw the empathic care that women and their families need, as a way to protect themselves emotionally (Wallbank & Robertson, 2013). However, if they can manage such grief in a more positively affective way, they are more probably to provide good care to the women/families affected by perinatal death, thus enhancing their welfare (Dahò, 2020). The care provided for these women/families is key to helping them feel supported, cared for and relieved of their suffering (Chan et al., 2008), a central tenet of the nursing profession (Dempsey et al., 2014; Lown, 2018).

Perinatal death occurs in multiple types of scenarios. It can occur in maternity units or in Perinatal Hospice (PH) units. There exist various forms of PH or Neonatal Palliative Care (NPC) (Flaig et al., 2019; Kain & Chin, 2020; Miller et al., 2014) across the world, in which nursing care is also provided. Although these units are not equally well known or similarly widespread (Cerratti et al., 2020; Gruszka et al., 2019; Zhong et al., 2022), nurses and midwives who work in such units are required to deal with stillbirth and perinatal death more often than in a common maternity unit. Often located in NICUs, these programmes and units have proved to be very useful (with psychological benefits) for both families and professionals (Dahò, 2021). Notwithstanding the above, the way nurses/midwives experience their care of people suffering perinatal death situations may be different in PH or maternity units, for several important reasons. These include the following: the nature of the situation (foreseen or unforeseen) and the family's subsequent choices—for example to go forward or not with the pregnancy of a foetus affected by a medical condition that is incompatible with life (Dahò, 2020); the time available to plan the care for the women/families (André et al., 2020); the previous training of the nurses/midwives (Laing et al., 2020; Shen et al., 2022); the extent to which the organizational culture of the team and the centre is death-oriented (André et al., 2020); and the existence of protocols to deal with this type of situation (also after hospital discharge) along with other kinds of institutional support (Camacho Avila et al., 2020; Fernández-Alcántara et al., 2020). This review will focus on the care provided in the latter clinical setting (maternity units), including obstetric and gynaecologic settings.

2 | BACKGROUND

Caring for and supporting women whose children have died, and their families, is extremely demanding and stressful (Chan et al., 2003; Martos-López et al., 2016). Being satisfied at work (defined as a positive affective response to the situation lived at work, Mottaz, 1985) may greatly help to provide the required quality of care (Gensimore et al., 2020). Faced with the difficulties that arise, nurses/midwives may feel they are failing and experience dissatisfaction, because they perceive they can neither do anything for the parents nor mitigate the loss. Thus, some nurses/midwives report they need to distance themselves from these women/families, as they feel they cannot cope with all their feelings (Chan et al., 2008). This detachment can lead to the perception that they are uncaring or are not providing the necessary care (Cacciatore, 2013), which is exacerbated if, in the culture of the affected family, death is taboo and nursing professionals need to make an extra effort to identify these families' feelings (Steen, 2015).

The significant emotional burden experienced by nurses and midwives in perinatal death situations probably intensifies their insecurities (Wallbank & Robertson, 2013), becoming a test of these professionals' self-care capabilities (Willis, 2019). While, in these situations, midwives and nurses would need to know how to manage their discomfort and grief both professionally and personally (Chan et al., 2003; Fenwick et al., 2007), many may not be adequately prepared to deal with these situations (Hernández Garre et al., 2017). As a result, their level of satisfaction with the situation may be harmed (Willis, 2019), because of experiences of negative feelings such as grief, sadness, fear, anxiety, stress, headache, insomnia or anger (Hernández Garre et al., 2017).

While the available literature on how to improve the well-being of the families who experience perinatal death has focused on the needs and experiences of parents, there is a relative lack of studies on the needs of nurses and other healthcare professionals (Shorey et al., 2017). However, a better identification of what it is that these professionals experience and the factors that can help them manage the situation successfully or improve their satisfaction with the situation could be of value in improving the quality of the care provided to the affected families (Lal, 2021).

While some studies have examined caregivers' experiences of perinatal deaths, their behaviours and needs (Chan et al., 2005), others have examined factors that may positively influence these experiences (Shorey et al., 2017)—such as age, years in practice, forms of coping and social support (Mollart et al., 2013)—and which can improve the care provided to the families affected (Callister, 2006). However, research still lacks comprehensive and synthetized information on what occurs to nurses/midwives' satisfaction in these situations and the factors that can help these health workers to cope with them with a more positive affective mood.

3 | THE REVIEW

3.1 | Aim

This research was conducted to synthesize the existing findings from both quantitative and qualitative studies exploring nurses' and midwives' experiences and coping strategies in perinatal death situations. The aim was thus to answer a twofold research question: "How does the experience of dealing with perinatal death situations affect nurses' and midwives' satisfaction at work and what strategies can help these professionals to improve their satisfaction as well as deal with this situation more effectively to provide higher-quality care to the affected families?"

3.2 | Design

We conducted a qualitative systematic literature review, without carrying out a meta-analysis, guided by the Preferred Reporting Items for Systematic Reviews and Meta-Analysis (PRISMA) protocol, following previous recommendations (Urrutia & Bonfill, 2010). The five components of the research questions we aimed to answer in this study, according to the PICOS format (see Liberati et al., 2009), were as follows: (a) **P**articipants: nurses and midwives attending to people in perinatal death situations; (b) **I**ntervention: not described; (c) **C**omparison: nurses and midwives who attend to perinatal death situations and nurses and midwives who do not attend to perinatal death situations; (d) **O**utcomes: impact on the level of satisfaction of nurses and midwives who experience a perinatal death; and (e) **S**tudy design: all types of studies are included, except for review studies.

3.3 | Search methods

The search was implemented in the following databases: Web of Science, PubMed, Scopus, CINALH and Dialnet, for articles in English and Spanish from the period between January 2000 and March 2021. The terms used for the search were "perinatal bereavement", "nursing", "midwives", "nurse", "satisfaction", "perinatal mourning", "perinatal grief", "perinatal bereavement", "nursing", "midwives". The Boolean operators "and" and "or" were used to combine the terms used in the search to link the different words in a logical way.

The studies included in our analysis are those published in Spanish and English between 2000 and 2021, whose participants were nurses and midwives who had dealt with situations of perinatal death. An inclusion criterion was that the studies should provide data on the perceptions of professionals when caring for people who are grieving a perinatal death. In addition, the studies included had to respond to the PICOS research question described above.

3.4 | Search outcomes

The initial search in electronic databases yielded 373 articles: Web of Science (n = 60), PubMed (n = 224), CINALH (n = 68), Dialnet (n = 13) and Scopus (n = 8). These records were manually evaluated by two independent authors, while a third was asked to discuss any disagreements with them until a consensus could be reached. In addition, a manual search of reference lists of relevant studies identified 7 additional articles, and thus, the search yielded a total number of 380 articles. However, after eliminating duplicate records, a total of 164 articles were finally evaluated by title, abstract, for availability in full text and by type of study (excluding reviews), which ultimately resulted in 43 complete research articles to be considered for inclusion in our systematic literature review.

3.5 | Eligibility criteria

The following eligibility criteria were applied: (a) studies specifically focused on perinatal loss and bereavement; (b) studies with participants who were nurses or midwives; (c) studies that examined nurses/midwives' perceptions. All study designs (except for review studies) were eligible for inclusion. Of the 43 complete articles that were considered for inclusion in the study, 30 articles were excluded as they failed to meet the inclusion criteria (failure to focus specifically on perinatal loss and bereavement, failure to include at least one nurse/midwife among the participants or failure to make any reference to nurses/midwives' perceptions). Finally, 13 articles were included (see Table 1). All these articles reported on nurses' and/or midwives' perceptions of perinatal death situations, and all of them met the inclusion criteria according to the PICOS research questions previously described. Figure 1 details the complete process.

3.6 | Data extraction

Data were extracted from studies included through a data extraction form for qualitative studies. Extracted data from primary sources included the author and year, country, study type, sample, evaluation/objective and results.

3.7 | Quality appraisal

To measure the level of quality of all the studies, a table for study quality assessment was used (see Table 2), following recent guidelines in this field (López de Argumedo et al., 2017). The analysis revealed low bias and medium-high quality for all the studies included in the review.

3.8 | Synthesis of results

A narrative synthesis of the data was undertaken. From each study, we extracted the sample size, the assessment conducted and the key findings (in terms of aspects related to nurse/midwives' attitudes, perceptions and coping strategies)

4 | RESULTS

4.1 | Characteristics of the studies included

Table 1 reflects a brief synthesis of all the 13 studies reviewed in this research. The main results are also presented in Table 3, where the articles are arranged in chronological order.

As seen in Tables 1 and 3, the 13 studies were published over 19 years (2003–2021), mainly in Asia (38.5%), Europe (30.7%), North America (23.1%) and Oceania (7.7%). Sample sizes in the studies ranged from 6 to 533 participants (nurses/midwives), and the overall

TABLE 1 Overview of the 13 studies used in the systematic review

Country of the sample
China (4)
Spain (2)
Italy (2)
The United States (2)
Canada (1)
Australia (1)
China + Singapore (1)
Study type/Data analysis
Qualitative analysis
Descriptive, using in-depth interviewing (1)
Descriptive, using in-depth interviewing or focus groups and interpretive phenomenology (3)
Descriptive, using open-ended questionnaires and thematic analysis (1)
Quantitative Analysis
Inferential statistics and descriptive, using structured questionnaires (7)
Descriptive analysis, using structured and open-ended questionnaires (1)
Study design
Convenience sampling and cross-sectional (13)
Population
Sample size
Mean sample size: 168.92 (Min = 6 participants; Max = 533 participants). Total = 2196 participants.
Age
Min = between 18 and 25 years old; Max. = 65 years old.
Work experience
Min = 3 years; Max. = 21 years.

Note: Age was not explicitly reported in Fenwick et al. (2007), so the age-related values indicated in this table were calculated for all other studies. Work experience was not reported in Steen (2015), so the work experience-related values here reported in this table refer to all the studies except this one.

sample across all the studies amounted to a total of 2196 participants (nurses/midwives) (see Table 1). In general, as Table 1 reflects, all ages were represented; participant ages ranged from a minimum of 18–25 years to a maximum age of 65 years. Additionally, all participants had a minimum of 3 years of work experience (see Table 1).

Tables 1 and 3 also report interesting aspects of the design and methods of the studies analysed. In terms of design, studies were cross-sectional and used convenience sampling. In terms of methods, most were classified as quantitative ($n = 8$ studies, 1 was descriptive and 7 mixed descriptive analysis with inferential statistics), while the remaining studies were classified as qualitative ($n = 5$). For the quantitative studies ($n = 8$), structured questionnaires were mostly used (1 study also used open-ended questions in the questionnaire), and regarding the qualitative studies ($n = 5$), in-depth interviews and focus groups were generally used ($n = 4$); only one qualitative study used open-ended questionnaires. Interestingly, in analysing the data collected, the qualitative studies used techniques such as interpretive phenomenology ($n = 3$) and thematic analysis ($n = 1$).

4.2 | Perinatal care settings

As seen in Table 3, all the studies included in our systematic literature review assessed the attitudes, experiences and needs of nursing care providers in dealing with perinatal death situations. All participants also carried out their work in maternity units, including obstetric and gynaecological settings, except one neonatal intensive care nurse in the study by Jonas-Simpson et al. (2013) and a midwife from a primary health centre in the study by Martínez-Serrano et al. (2018).

4.3 | Findings on a high level of satisfaction among nurses and midwives

Several studies were specific to nursing/midwives' high satisfaction, positive experiences and attitudes to care in perinatal death situations (Chan et al., 2003; Fenwick et al., 2007; Jonas-Simpson et al., 2013; Ravaldi et al., 2018). Eight studies addressed different successful strategies to cope with this situation (Chan et al., 2003, 2004, 2005, 2008; Jonas-Simpson et al., 2013; Ravaldi et al., 2018; Steen, 2015; Willis, 2019).

4.4 | Findings on a low level of satisfaction among nurses and midwives

Six studies showed low levels of satisfaction among nurses and midwives attending to women/families in perinatal death situations (Fenwick et al., 2007; Gandino et al., 2020; Jonas-Simpson et al., 2013; Pastor Montero et al., 2011; Steen, 2015; Willis, 2019). All the studies included in this systematic literature review address the subject of strategies that nurses/midwives feel are not being implemented at all or that are being insufficiently implemented.

5 | DISCUSSION

5.1 | Positive factors and successful coping strategies to elevate satisfaction at work

While previous literature has usually focused on the negative effects of perinatal death on nurses' work and personal life (e.g. moral distress, fatigue, burnout and stress), our review has shown a different picture. Specifically, it has revealed that it is possible for nurses/midwives to be satisfied at work and even to feel happiness in a context of death.

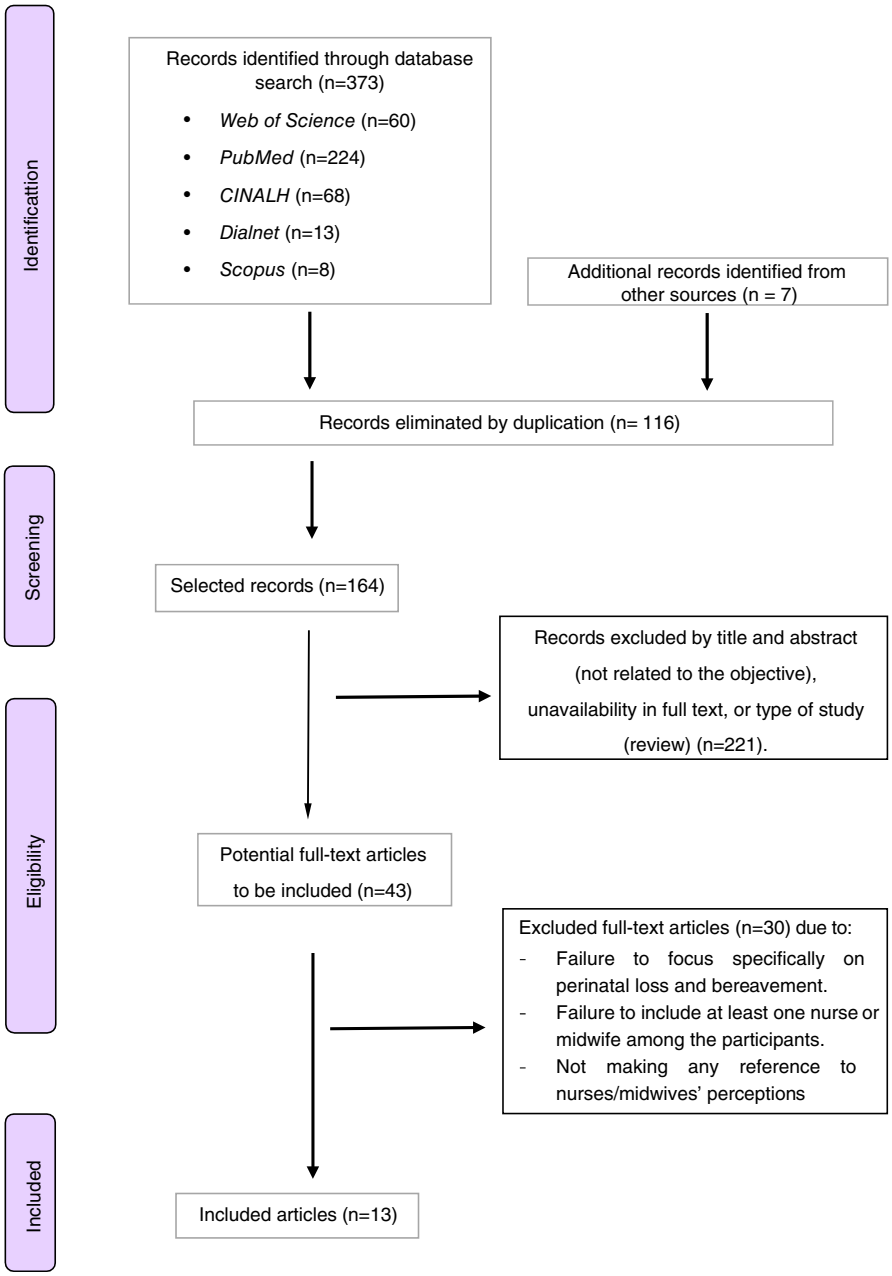

FIGURE 1 PRISMA flowchart describing the selection process.

TABLE 2 Evaluation of the quality of each study

Research question: Is the study based on a clearly defined research question?	Yes	No	Partially	No information
Method: Did the study method minimize bias?	Yes	No	Partially	No information
Results: Are the results correctly synthesized and described?	Yes	No	Partially	No information
Conclusions: Are the conclusions justified?	Yes	No	Partially	No information
Conflict of interest: Is the existence or absence of conflict of interest well described?	Yes	No	Partially	No information
External validity: Are the results of the study generalizable to the population and context of interest?	Yes	No	Partially	No information
	Method		Method	Method
	YES		PARTIAL	NO
Majority of other criteria *YES*	High Quality		Medium Quality	Low Quality
Majority of other criteria *PARTIALLY*	Medium Quality		Medium Quality	Low Quality
Majority of other criteria *NO*	Low Quality		Low Quality	Low Quality

TABLE 3 General characteristics of the studies

Authors/year	Country	Study type	Sample size and setting	Evaluation/objective	Results	Quality
Chan et al. (2003)	China	Quantitative (Inferential statistics and descriptive analysis).	110 nurses from Obstetrics and Gynaecology (OAG) units.	Nurses' attitudes toward the support (to be received) during a perinatal bereavement situation.	Only 25.5% had had bereavement-related training. About 93.6% needed and were interested in bereavement care training and in knowledge and skills in this area. Additionally, more than 90% sought opportunities to express their feelings and experiences and sought support when feeling stressed.	High
Chan et al. (2004)	China	Quantitative (Inferential statistics and descriptive analysis).	110 nurses from OAG units.	Nurses' attitudes toward perinatal bereavement care.	Nurses highlight the need for increased knowledge, experience, communication skills, and support from team members and the hospital. Only 25.5% ($n = 28$) had had bereavement-related training.	High
Chan et al. (2005)	China	Quantitative (Inferential statistics and descriptive analysis).	169 nurses from OAG units.	Nurses' attitudes toward perinatal bereavement care.	Nurses highlight the need for increased knowledge, experience, communication skills and support from team members and the hospital. Only 29.6% had had bereavement-related training.	Medium
Fenwick et al. (2007)	Australia	Qualitative, descriptive study (using thematic analysis)	140 midwives and nurses from maternity hospitals.	Midwives' and nurses' experience, confidence and satisfaction in providing care to women experiencing perinatal loss.	The most satisfying aspect was connecting with families, responding to their needs and providing them with support. The least satisfying aspect was emotional engagement.	Medium
Chan et al. (2008)	China	Quantitative (Inferential statistics and descriptive analysis).	334 nurses from OAG units.	Nurses' attitudes toward perinatal bereavement care and factors associated with those attitudes.	Nurses emphasized their need for more knowledge, experience, improved communication skills, and support from team members and the hospital for perinatal bereavement care.	High
Chan et al. (2010)	China and Singapore	Quantitative (Inferential statistics and descriptive analysis).	573 nurses from OAG units.	Nurses' attitudes toward perinatal bereavement care in three Asian cities and factors related to these attitudes.	Older and experienced nurses had a more positive and supportive attitude than younger and inexperienced nurses. Less than 21% had taken any courses related to perinatal bereavement.	Medium
Pastor Montero et al. (2011)	Spain	Qualitative descriptive study (using in-depth interviewing and interpretive phenomenology)	19 health professionals from Maternal–Infant units. (89.47% were nurses/midwives)	Experiences of health professionals in situations of death and perinatal bereavement and strategies for dealing with perinatal loss.	The inappropriate attitudes often adopted when caring for a family experiencing a perinatal loss are caused by a lack of knowledge and skills to deal with these situations. This can generate anxiety and helplessness.	Medium
Jonas-Simpson et al. (2013)	Canada	Qualitative descriptive study (using in-depth interviewing and interpretive phenomenology).	5 obstetric nurses and 1 neonatal intensive care nurse.	Obstetric and neonatal nursing staff's experiences of caring for bereaved families who have experienced a perinatal death.	Recognition, support and education are needed. When their bereavement experiences are recognized, nurses may feel more supported, which could have a positive impact on the quality of their work and home lives.	High
Steen (2015)	US	Quantitative (Inferential statistics and descriptive study.	42 US nurses and 2 US midwives. 5 Spanish nurses and 10 Spanish midwives from OAG units.	Needs and concerns of nurses and midwives who have dealt with perinatal death, as well as interventions they use to help families with this experience.	Talking to family and friends was very useful for the nurses to help them cope with these situations. Lack of training and of knowledge and skills is the cause of the negative attitudes and discomfort of healthcare workers in these situations.	Medium

TABLE 3 (Continued)

Authors/year	Country	Study type	Sample size and setting	Evaluation/objective	Results	Quality
Martínez-Serrano et al. (2018)	Spain	Qualitative, descriptive study (using focus groups)	18 midwives from maternity units and a primary health centre.	Midwives' experiences of delivery care in late foetal demise.	Organizations are not prepared for these events. There is a lack of training and lack of continuity of care. For health professionals, the existence of support networks is positive.	High
Ravaldi et al. (2018)	Italy	Quantitative. (Descriptive study).	673 health professionals from OAG units (79.20% were nurses/midwives).	Current practices of healthcare professionals caring for women experiencing foetal death and their training needs to better support them and their families.	75% of healthcare professionals had never attended a course on perinatal bereavement care. Healthcare professionals feel the urgent need for training to better meet the needs of women and families in these situations.	High
Willis (2019)	US	Qualitative descriptive study (using in depth-interviewing)	9 nurses from labour and delivery units.	Nurses' experiences in caring for women suffering from a perinatal loss and the process nurses follow in response to these situations.	Five main themes: wrestling with emotions, continuing with the moment, being present for the patient, expressing conflict, and taking care of oneself. Addressing these situations can impact nurses' personal and professional lives.	Medium
Gandino et al. (2020)	Italy	Quantitative (Inferential statistics and descriptive analysis).	38 nurses and 80 midwives from maternity units.	Emotional impact on healthcare professionals of caring for parents suffering a perinatal loss.	Nurses/midwives are more involved in providing emotional support and helping mothers and families suffering from a perinatal loss. Hospital staff are influenced by the emotional impact of perinatal loss. The category of words most used by participants was *negative emotions* (sadness, anxiety, anger).	Medium

In contrast to studies such as André et al. (2020), Gruszka et al. (2019) and Shen et al. (2022), Chan et al. (2003) showed that the majority of nurses (90.9%) felt positive attitudes and feelings when they provided bereavement care, while Ravaldi et al. (2018) reported that a large proportion of nurses (76.8%) felt that they were providing adequate support for the family. In fact, our literature review reveals that high satisfaction usually emerges when nurses/midwives: (a) develop a holistic approach to care, (b) have the ability to provide women and families with opportunities to be with the newborn and (c) can develop postpartum care (Fenwick et al., 2007).

Of the strategies used to cope with this tragic situation, sharing experiences, feelings and concerns with others—especially with peers—are the most commonly reported in line with the results of many other studies not included in this review (André et al., 2020; Laing et al., 2020; Martos-López et al., 2016). This is because "these others" may have experienced similar situations in the past and are, therefore, more probably to understand their experiences of grief. Furthermore, Willis (2019) reported that nurses who felt understood by others found it easier to continue to help and care for women who had experienced a perinatal death. Related to this, Chan et al. (2003, 2008) also found that having opportunities to express one's feelings and needs was critical to one's well-being, and this finding has been supported in subsequent research (Jonas-Simpson et al., 2013; Steen, 2015; Willis, 2019).

Another interesting coping strategy in these situations is being empathetic or putting oneself in the place of these families. Ravaldi et al. (2018) found that it worked, as nurses/midwives who were empathetic seemed to have a lower level of burnout. In addition, Jonas-Simpson et al. (2013) reported that developing attitudes aimed at comforting affected women and their families also helped to comfort nurses/midwives. Finally, in other studies, nurses/midwives showed positive attitudes and feelings towards the opportunity of participating in bereavement counselling programmes (Chan et al., 2005; Jonas-Simpson et al., 2013), as it was believed to be a factor that improves their satisfaction at work in these situations. Chan et al. (2003), for example, found that nurses/midwives showed an interest in being equipped with relevant knowledge and skills in bereavement-care training (93.6%), and in having opportunities to express their own feelings and be supported by colleagues (>90%), all to be more satisfied at work in these situations. Additionally, in other studies, nurses/midwives showed positive attitudes towards the opportunity of participating in bereavement counselling programmes (Chan et al., 2005; Jonas-Simpson et al., 2013), which could probably be a factor that improves their satisfaction at work in these situations. The latter findings are unsurprising, as many studies show that there may be a deficit in this type of training (Shen et al., 2022), which makes it difficult for nurses/midwives to acquire and develop basic care skills with which to successfully attend to the women and families affected by perinatal death situations (Laing et al., 2020).

5.2 | Negative factors and coping strategies to implement to elevate satisfaction at work

A focus on factors that can be source of dissatisfaction at work in perinatal death situations is key to designing strategies that can limit this outcome, and our systematic literature review revealed many points that favoured a negative impact on the nurses/midwives´ satisfaction—both at work and in personal domains—from the provision of a deficient perinatal bereavement care.

Training deficits in bereavement care are a factor highlighted by many studies as a source of professional dissatisfaction (Hernández Garre et al., 2017; Laing et al., 2020; Martos-López et al., 2016) and of dissatisfaction among families affected by perinatal death (Camacho Avila et al., 2020). In the studies by Chan et al. (2003, 2004), nurses refer, for example, to the need for more knowledge, experience and communication skills to provide optimal care for women/families in this situation (only 25.5% of the participants in these studies had training in perinatal bereavement). Also, Chan et al. (2005) show that many professionals consider their understanding of the bereavement situation to be merely instinctive, and in relation to this, Ravaldi et al. (2018) reveal that many of their actions were based on personal beliefs and guided only by compassion; in their study, 75% of nurses/midwives had never attended a course on perinatal bereavement care (Ravaldi et al., 2018), a widespread pattern (Chan et al., 2008, 2010) that, for Jonas-Simpson et al. (2013), could be solved by providing bereavement education in nursing schools or even at work. Our results about training deficits are in line with previous research that has shown a great variability in the bereavement care offered to families, probably resulting from the absence of guidelines on care, in both NPC/PH settings (Cerratti et al., 2020; Dahò, 2021) and mixed settings (NPC-PH/Obstetrics and Gynaecology [OAG]; Fernández-Alcántara et al., 2020; Gruszka et al., 2019).

Another source of dissatisfaction was the negative emotional and physical impact of having lived through this tragic situation. Willis (2019), for example, revealed that experiencing perinatal death had a negative emotional impact on the nurses' lives, and Pastor Montero et al. (2011) and Gandino et al. (2020) showed that study participants (nurses and midwives) had not only coped with their own feelings, but also with the feelings of the affected families, which is consistent with other studies (see André et al., 2020). The midwives studied by Fenwick et al. (2007) also stated that the emotional commitment required to care for a family in a situation of perinatal death was deeply unsatisfactory. Finally, while Jonas-Simpson et al. (2013) reported that nurses took their grief home with them on many occasions, Willis (2019) found that many participants cited their inability to forget these experiences and even to sleep because of these thoughts. As anticipated, this negative experience of having lived through this exhausting situation is not only psychological, but also physical (Gandino et al., 2020; Martos-López et al., 2016) and is a source of avoidance reactions that negatively affect the care to be provided (Steen, 2015), with nurses/midwives probably to hesitate

to attend to patients' emotional needs because they do not want to be hurt.

Despite all these important sources of dissatisfaction, the age of the professionals may moderate the negative impact of these factors. Indeed, in the study by Chan et al. (2004), older nurses—who had additional training as midwives, more experience in bereavement care, personal bereavement experiences and skills in helping bereaved persons—were more prepared and knowledgeable about the practices required to care for bereaved women/families. Chan et al. (2008) also showed that older (and more experienced) nurses had a more positive and supportive attitude in perinatal death situations than younger and inexperienced nurses. Notwithstanding the above, Gandino et al. (2020) showed that nurses/midwives with less work experience used more negative words, thus indicating that in bereavement care, it is work experience, rather than age, that is probably the important factor in cushioning the negative impact of any source of dissatisfaction. These results are in line with other previous research (Mollart et al., 2013) that also reveals that for midwives, the years of work experience reduce their stress levels.

Finally, previous literature has already highlighted the important role of social support from peers and supervisors in improving nurses' well-being (André et al., 2020; Gensimore et al., 2020; Haizlip et al., 2020; Lal, 2021; Lown, 2018; Wallbank & Robertson, 2013). In this regard, the systematic literature review we carried out suggests that having institutional support—clear policies and guidelines that recognize the needs of nurses and midwives working in OAG and maternity units—may be of great importance in improving the satisfaction of nurses/midwives experiencing a perinatal death situation (e.g., Chan et al., 2004). This is not new in the literature but confirms previous literature (Shorey et al., 2017) in which several examples of institutional support (e.g. use of mentorship) have already been reported to be very enriching for the mentee, both personally and professionally (Miller et al., 2020). Thus, it would be of interest for nurses/midwives to be provided with a mentor (preferably, experienced nurses/midwives in these situations) and training on how to be empathetic, as it may enhance the work life and satisfaction of less experienced nurses/midwives who suffer in perinatal death situations. Other supportive interventions that previous research has reported to be successful and that could also be applied to perinatal death situations could be the design of sessions of mindfulness (Cacciatore, 2013) or positive psychology (van Horne et al., 2020).

Otherwise, the absence of any institutional support is probably to cause nurses to express frustration as they may see their needs as going unrecognized (Steen, 2015; Willis, 2019). Likewise, this support needed to avoid low satisfaction at work is also related to the implementation of an adequate configuration of healthcare facilities and flexibility to change job positions and interrupt working time, so that nurses/midwives can continue to work in a different location or section or in another job position after living through a perinatal death situation. As Martínez-Serrano et al. (2018) indicate, midwives sometimes find that they have to attend to one family suffering a perinatal death, while, in the next room, they have to attend to other families who have had a healthy birth. This situation generates the paradox of death appearing in a place that at the same time enables and welcomes life (Gandino et al., 2020), which is stressful for nurses/midwives, as it involves them having to change their behaviour quickly, despite not being mentally prepared to do this.

5.3 | Limitations

This systematic literature review is not without its limitations. First, the review focused on the care provided by nurses/midwives in maternity units, but other insightful results might have been found if this review had also included in its analysis the care provided by these professionals in other clinical settings. Second, we used a few keywords without including others that would have allowed us to integrate more insightful studies in the field, such as "perinatal hospice", "comfort care", "neonatal hospice" or "neonatal palliative care". Finally, we did not search grey-literature databases, and so some relevant studies in this field might not have been included in this review.

6 | CONCLUSION

Perinatal death situations may damage nurses/midwives' satisfaction at work. However, the studies reviewed here point to the opportunity of reducing, or even avoiding, significant harm to nurses' and midwives' satisfaction at work through different coping strategies. Thus, *how* to manage these situations as appropriately as possible is something that nurses, midwives and nursing managers should learn. The following seem to be protective factors against the occurrence of such dissatisfaction: older age and experience in perinatal care; coping strategies based on communicating one's feelings to peers; empathetic listening to the families cared for; training to acquire knowledge, experience and skills to deal with these situations; and institutional support in the form of both social support from team members and adequate management of the structure and processes of care for perinatal death situations. All things considered, we can conclude that nursing managers should implement training and counselling initiatives (e.g. workshops) aimed at training nurses/midwives in how to manage perinatal death situations that need bereavement care. These initiatives should include guidelines on *how* to support and communicate with mothers and their families, as well as how to support colleagues and oneself. Another strategy could be to allocate high-risk women in childbirth to bereavement care-experienced nurses/midwives who are experienced in bereavement care, and for each professional to have sufficient time to recover from such a negative situation. Clear policies should allow these professionals not to attend to other women in childbirth during their shifts. Finally, if the nursing management were to provide spaces (virtual and physical) for nurses/midwives to share their own feelings and concerns with other colleagues, as well as to find support, this could help them improve emotionally and learn how to properly deal with these situations. In short, our review shows that

it is possible for nurses and midwives to feel satisfied with their work in a context of death, and that it is possible to do so and therefore to live and work better.

AUTHOR CONTRIBUTIONS

Cristina Garcia-Catena and Juan D. Gonzalez-Sanz conceived the paper. Cristina Garcia-Catena and Steven Saavedra designed and conducted the bibliographic search. Cristina Garcia-Catena and Steven Saavedra studied abstracts and titles of articles. Juan D. Gonzalez-Sanz resolved disagreements. Cristina Garcia-Catena and Steven Saavedra screened the full texts, extracted and analysed the data. Cristina Garcia-Catena and Pablo Ruiz-Palomino wrote the draft with inputs from Steven Saavedra and Juan D. Gonzalez-Sanz, who provided guidance during the process. All authors read and approved the final version of the manuscript.

FUNDING INFORMATION

None to declare.

CONFLICT OF INTEREST

No conflict of interest has been declared by the author(s).

PEER REVIEW

The peer review history for this article is available at https://publons.com/publon/10.1111/jan.15572.

DATA AVAILABILITY STATEMENT

Research data are not shared.

ORCID

Pablo Ruiz-Palomino https://orcid.org/0000-0002-0413-8512
Steven Saavedra https://orcid.org/0000-0002-2902-3447
Juan D. Gonzalez-Sanz https://orcid.org/0000-0002-4344-8353

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How to cite this article: Garcia-Catena, C., Ruiz-Palomino, P., Saavedra, S., & Gonzalez-Sanz, J. D. (2023). Nurses' and midwives' perceptions and strategies to cope with perinatal death situations: A systematic literature review. *Journal of Advanced Nursing*, *00*, 1–12. https://doi.org/10.1111/jan.15572